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CORRECTIONS

In the article by Fleisher LA et al., "ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to Revise the 2002 Guidelines on Perioperative Cardiovascular Evaluation for Noncardiac Surgery)," which published ahead of print on September 27, 2007, and appeared in the October 23, 2007, online issue of the journal (J Am Coll Cardiol 2007;50:e159–242), the following corrections were necessary:

1. On page e159, under "Writing Committee Members," Dr. Chaikof's name has been updated to read "Elliot L. Chaikof."
2. On page e168, in the left-hand column, under the "2.7.1. Stepwise Approach to Perioperative Cardiac Assessment" heading, the following recommendations have been added at the beginning of this section to be consistent with the recommendations in Figure 1:

Recommendations for Perioperative Cardiac Assessment

Class I

1. Patients who have a need for emergency noncardiac surgery should proceed to the operating room and continue perioperative surveillance and postoperative risk stratification and risk factor management. *(Level of Evidence: C)*
2. Patients with active cardiac conditions* should be evaluated and treated per ACC/AHA guidelines and, if appropriate, consider proceeding to the operating room. *(Level of Evidence: B)*
3. Patients undergoing low risk surgery are recommended to proceed to planned surgery.† *(Level of Evidence: B)*
4. Patients with poor (less than 4 METs) or unknown functional capacity and no clinical risk factors‡ should proceed with planned surgery.† *(Level of Evidence: B)*

Class IIa

1. It is probably recommended that patients with functional capacity greater than or equal to 4 METs without symptoms§ proceed to planned surgery.‖ *(Level of Evidence: B)*
2. It is probably recommended that patients with poor (less than 4 METs) or unknown functional capacity and 3 or more clinical risk factors‡ who are scheduled for vascular surgery consider testing if it will change management.¶ *(Level of Evidence: B)*
3. It is probably recommended that patients with poor (less than 4 METs) or unknown functional capacity and 3 or more clinical risk factors‡ who are scheduled for intermediate risk surgery proceed with planned surgery with heart rate control.¶ *(Level of Evidence: B)*
4. It is probably recommended that patients with poor (less than 4 METs) or unknown functional capacity and 1 or 2 clinical risk factors‡ who are scheduled for vascular or intermediate risk surgery proceed with planned surgery with heart rate control.¶ *(Level of Evidence: B)*

Class IIb

1. Noninvasive testing might be considered if it will change management for patients with poor (less than 4 METs) or unknown functional capacity and 3 or more clinical risk factors‡ who are scheduled for intermediate risk surgery. *(Level of Evidence: B)*
2. Noninvasive testing might be considered if it will change management for patients with poor (less than 4 METs) or unknown functional capacity and 1 or 2 clinical risk factors‡ who are scheduled for vascular or intermediate risk surgery. *(Level of Evidence: B)*

*See Table 2 for active clinical conditions. †See Class III recommendations in Section 5.2.3. Noninvasive Stress Testing. ‡Clinical risk factors include: ischemic heart disease, compensated or prior heart failure, diabetes mellitus, renal insufficiency, and cerebrovascular disease. §See Table 3 for estimated MET level equivalent. ‖Noninvasive testing may be considered before surgery in specific patients with risk factors if it will change management. ¶Consider perioperative beta-blockade (see Table 12) for populations in which this has been shown to reduce cardiac morbidity/mortality.

3. In Figure 1, page e169:
   - A footnote symbol (dagger) has been added to the "Proceed with planned surgery" box in Step 3 and Step 5. The corresponding footnote reads: "†See Class III recommendations in Section 5.2.3. Noninvasive Stress Testing."
   - Step 4, which read "Good functional capacity (MET level greater than or equal to 4) without symptoms†," has been changed to read: "Functional capacity greater than or equal to 4 METs without symptoms‡."
   - The class of recommendation in Step 4 has been changed from Class I to Class IIa to read: "Class IIa, LOE B."
   - A footnote symbol (section mark) has been added to the "Proceed with planned surgery" box in Step 4. The corresponding footnote reads: "§Noninvasive testing may be considered before surgery in specific patients with risk factors if it will change management."
   - In the figure legend, "specific patient populations" has been changed to "specific patients" in the footnote that began "Noninvasive testing."
   - In the figure legend, "(see Table 11)" has been changed to "(see Table 12)" in the footnote that began "Consider perioperative beta blockade."
   - The figure legend has been updated with these changes to read: *See Table 2 for active clinical conditions. †See Class III recommendations in Section 5.2.3. Noninvasive Stress Testing. ‡See Table 3 for estimated MET level equivalent. §Noninvasive testing may be considered before surgery in specific patients with risk factors if it will change management. ‖Clinical risk factors include ischemic heart disease, compensated or prior heart failure, diabetes mellitus, renal insufficiency, and cerebrovascular disease. ¶Consider perioperative beta blockade (see Table 12) for populations in which this has been shown to reduce cardiac morbidity/mortality. ACC/AHA indicates American College of Cardiology/American Heart Association; HR, heart rate; LOE, level of evidence; and MET, metabolic equivalent.
4. On page e170, in the left-hand column, the first complete paragraph, the first sentence, which read "Step 4: Does the patient have good functional capacity without symptoms?" has been changed to read: "Step 4: Does the patient have a functional capacity greater than or equal to 4 METs, without symptoms?"
5. On page e170, in the left-hand column, second complete paragraph, third sentence, the range for "moderate functional capacity" has been changed from ". . .moderate (4 to 7 METs). . ." to: ". . .moderate (4 to 6 METs). . . ."
6. On page e181, in the right-hand column, the first recommendation under Class IIb for "Recommendations for Noninvasive Stress Testing Before Noncardiac Surgery," "noncardiac" has been changed to "or vascular," to read: "Noninvasive stress testing may be considered for patients with at least 1 to 2 clinical risk factors and poor functional capacity (less than 4 METs) who require intermediate-risk or vascular surgery if it will change management. *(Level of Evidence: B)*"
7. On page e181, in the right-hand column, the second recommendation under Class IIb for "Recommendations for Noninvasive Stress Testing Before Noncardiac Surgery" has been deleted ("2. Noninvasive stress testing may be considered for patients with at least 1 to 2 clinical risk factors and good functional capacity (greater than or equal to 4 METs) who are undergoing vascular surgery. *(Level of Evidence: B)*").
8. In Figure 3, page e201:
   - The title has been changed to begin with the word "proposed," to read: "Proposed treatment for patients requiring percutaneous coronary intervention (PCI) who need subsequent surgery."
   - The COR/LOE indications have been removed.
9. On page e242, reference 575, which read "575. Berger PB, Holmes DR Jr., Stebbins AL, Bates ER, Califf RM, Topol EJ. Impact of an aggressive invasive catheterization and revascularization strategy on mortality in patients with cardiogenic shock in the Global Utilization of Streptokinase and Tissue Plasminogen Activator for Occluded Coronary Arteries (GUSTO-I) trial: an observational study. Circulation 1997;96:122–7." has been replaced with: "Berger PB, Bellot V, Bell MR, et al. An immediate invasive strategy for the treatment of acute myocardial infarction early after noncardiac surgery. Am J Cardiol 2001;87:1100–2."

These changes have been made to the current online version of the article, which is located at http://content.onlinejacc.org/cgi/reprint/50/17/e159.

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